BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **OLE G. TORJUSEN, M.D.** Holder of License No. 19487 For the Practice of Medicine In the State of Arizona.	Case No. MD-05-0456A MD-05-1003A MD-06-0196A **CONSENT AGREEMENT FOR SURRENDER OF ACTIVE LICENSE**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Ole G. Torjusen, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

OLE G. TORJUSEN, M.D.

Dated: 3/18/08

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 19487 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0456A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a thirty-one year-old female patient ("DM"); case number MD-05-1003A after receiving a complaint regarding Respondent's care and treatment of a nineteen year-old female patient ("JD"); and case number MD-06-0196A after Respondent failed to complete continuing medical education (CME) course in Diagnosis and Management of Obstetric Complications ordered by the Board in case number MD-01-0775.

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4. On February 5, 2001 DM presented to Respondent for an exploratory "[e]xamination under anesthesia, operative laparoscopy, lysis of adhesions" for chronic abdominal and pelvic pain. Respondent noted DM's history as "pre-op scopes and BTL [bilateral tubal ligation]". Respondent took DM to the operating room, made a 1.5 cm infraumbilical incision, placed DM in deep Trendelenburg position and inserted a sleeve and trochar. Respondent obtained pneumoperitoneum (gas in the abdominal cavity), inspected DM's pelvis, and found she had several loops of small bowel adherent to the anterior pelvic wall "right in the area where [DM]... complain[ed] about pain." Respondent made a second puncture probe in DM's midline, two finger widths above the synthesis and inserted a blunt manipulator. Respondent used a cautery and scissors to perform an adhesiolysis. Following the adhesiolysis procedure Respondent noted the bowel had not been violated. Respondent allowed 400 cc of normal saline to remain in DM's abdomen,

evacuated the pneumoperitoneum, and closed DM's abdomen. Following recovery Respondent discharged DM. The hospital records do not describe any further contact between Respondent and DM. Respondent did not provide his office records to Board as requested and therefore, Board Staff could not determine whether Respondent was aware of DM's past surgical history including an appendectomy, umbilical hernia repair, and right inguinal hernia repair. It is also unknown when Respondent initially saw DM for chronic abdominal and pelvic pain; how long he had followed her before electing to proceed with therapeutic laparoscopy and lysis of adhesions; or how aware Respondent was of DM's previous abdominal surgical history.

5. On February 9, 2001 DM was brought by ambulance to the emergency department (ED) with hypotension, diminished level of consciousness and abdominal pain. DM went into respiratory failure and was intubated by the ED physician ("ED Physician"). ED Physician's initial evaluation revealed renal failure with a positive disseminated intravascular coagulation and high fever sepsis with a severe abdominal distension and no abdominal bowel sounds. ED Physician ordered a computed tomography (CT) that confirmed evidence of bowel perforation. A general surgeon ("General Surgeon") took DM to the operating room with a preoperative diagnosis of acute abdomen. General Surgeon encountered a perforation of the cecum that she described as a secondary perforation of the hepatic flexure with gross fecal contamination and severe peritonitis. General Surgeon performed an exploratory laparotomy with a right hemicolectomy with an ileotransverse anastomosis.

6. Following surgery DM started to have some abdominal bowel sounds and bowel movement. However, on February 27, 2001 DM's temperature and white blood count started elevating. General Surgeon ordered an abdominal CT scan revealing fluid in DM's pelvis and abdominal area. General Surgeon performed re-exploration surgery to

drain the abdominal abscess, place the tracheostomy, and develop an enterocutaneous fistula. Following the second surgery, DM's condition stabilized and she was discharged on March 15, 2001.

7. The standard of care when performing therapeutic laparoscopy on a patient with substantial previous abdominal surgery requires a physician to use an open cannulation technique.

8. Respondent deviated from the standard of care because he did not use an open cannulation technique.

9. As a result DM suffered from a perforation of the cecum leading to peritonitis and sepsis with multiple subsequent operations and complications.

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10. On August 31, 2005 JD presented to Respondent after experiencing a large passage of blood from the vaginal area. JD reported being six weeks pregnant. Respondent performed an examination, noted JD had an infection, and took a culture sample. Respondent noted he did not feel JD was still pregnant and stated she probably had a spontaneous abortion. Respondent discussed ordering an ultrasound and blood test to determine whether there was a spontaneous abortion, but did not order the tests because JD did not have insurance and the tests were expensive. Respondent informed the Board JD refused testing because she did not want her mother to know about the pregnancy. Respondent told JD he would call her with the results and prescribed Monistat to help with her itching. On September 13, 2005 Respondent's office staff contacted JD with the results from the culture and confirmed she had an infection.

11. On September 15, 2005 JD presented to the ED because of increased vaginal bleeding and abdominal discomfort. The ED physician ("ED Physician #1") ordered an ultrasound that revealed no intrauterine pregnancy (IUP), but did reveal a thickened

endometrial stripe. ED Physician #1 noted products of conception could not be ruled out and ordered a human chorionic gonadotropin (hCG) test that was 6616, indicating a completed spontaneous abortion. ED Physician #1 noted JD looked well and discharged her with instructions to follow-up with the hospital obstetrician and gynecologist.

12. On September 21, 2005 JD returned to the ED with severe abdominal pain and vaginal bleeding. The ED Physician Assistant ("PA") ordered an hCG test that was 290, indicating an incomplete abortion. PA consulted the hospital gynecologist ("Gynecologist"). Gynecologist instructed JD to follow-up in his office on September 22, 2005. It is unknown whether JD followed up with Gynecologist.

13. On September 26, 2006 JD presented to the ED with severe abdominal pain and vaginal bleeding. ED Physician ("ED Physician #2") ordered an hCG test and noted it was 50 and an ultrasound that revealed heterogeneous material in the lower uterine segment. JD developed a fever of 100.2. ED Physician #2 noted tissue in the cervical canal and, after being unable to remove it in the ED, consulted a surgeon ("Surgeon") to discuss a dilatation and curettage procedure. After discussing the risks, benefits, indications, and alternatives with JD, Surgeon performed the dilatation and curettage procedure. The pathology report showed necrotic villi, indicating retained products of conception.

14. The standard of care requires a physician to perform appropriate testing, such as an ultrasound or blood testing, determine the correct diagnosis and treat a patient appropriately when the patient presents with vaginal bleeding early in pregnancy.

15. Respondent deviated from the standard of care because he did not perform appropriate testing, determine the correct diagnosis, and treat JD appropriately when she presented with vaginal bleeding early in pregnancy.

16. Respondent's failure to diagnose an incomplete abortion led to multiple hospital visits, an infection for JD and possible sepsis and potential death.

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17. On January 12, 2005 Respondent signed a Consent Agreement ("Agreement") for a Decree of Censure with one year Probation to complete twenty hours of continuing medical education (CME) in Diagnosis and Management of Obstetric Complications.

18. On February 12, 2006 the probationary period ended, but Respondent failed to complete the Board Ordered CME course.

19. On March 7, 2006 and March 22, 2006 Board Staff mailed notice letters to Respondent's home and office, respectively, alleging he violated the Agreement for failing to complete the Board Ordered CME course. Respondent was asked to respond by March 20, 2006 and March 31, 2006. Respondent did not respond.

20. On April 18, 2006 Board Staff mailed a re-notice letter to Respondent's home alleging he failed to furnish information in a timely manner. Respondent was asked to respond by May 2, 2006. Respondent did not respond.

21. On May 3, 2006 Board Staff contacted Respondent's office and requested he return the phone call. Respondent's office staff contacted Board Staff and stated Respondent had not been affiliated with them since fall 2005 and had left without notice and he may be living in Norway.

22. On May 3, 2006 Board Staff located an International cell phone number for Respondent and contacted him in Norway. Respondent stated he had not completed the required CME, but he did not want to lose his license. Respondent stated there was a four day conference in Scandinavia in three weeks and he would submit a brochure for pre-

approval. Board Staff asked Respondent to fax the brochure and submit a request for change of address.

23. On May 8, 2006 Respondent submitted the brochure and stated he would email the address change. Respondent did not email the address change. Board Staff reviewed the brochure and did not approve the CME course because the course description did not meet the terms of the Order. Board Staff attempted to contact Respondent, but was unsuccessful.

24. On June 20, 2006 Board Staff again attempted to contact Respondent. Board Staff received a voice mail and left a message asking Respondent to contact Board Staff immediately. Respondent did not respond.

25. Respondent admits to the acts described above and that they constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. §32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient"); A.R.S. §32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter"); and A.R.S. §32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigator or representatives if legally requested by the board").

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(q)("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(ll)("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(r)("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter").

5. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(dd) – ("[f]ailing to furnish information in a timely manner to the board or the board's investigator or representatives if legally requested by the board").

ORDER

IT IS HEREBY ORDERED THAT License Number 19487 issued to Ole G. Torjusen, M.D. for the practice of allopathic medicine in the State of Arizona, is surrendered and that Ole G. Torjusen, M.D. immediately return his wallet card and certificate of licensure to the Board.

DATED and effective this 3RD day of April, 2008.

ARIZONA MEDICAL BOARD

(SEAL)

By: _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed
this 3RD day of August, 2008 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed
this 3RD day of August, 2008 to:

Ole G. Torjusen, M.D.
Address of Record

_____
Investigational Review